PMIC Transition Workgroup Meeting Notes

Meeting #2
Friday, November 4, 2011
12:30 pm – 3:30 pm
Magellan
2600 Westown Pkwy., Suite 200
West Des Moines, Iowa

MINUTES

Attendance in person: Joan Discher, LeAnn Moskowitz, Jim Ernst, George Estle, Dan Freeman, Dennis Janssen, Belinda Meis, Kristie Oliver, Rick Shults, Jennifer Vermeer, Brock Wolff

Attendance by phone: Mike Barker

Facilitator: Beth Waldman

DHS Staff Present: Kelly Espeland, Julie Fleming, Laura Larkin,
Other Attendees:
Tonnie Guagenti, Orchard Place
Cliff Jackson, Recovery
Jess Benson, Legislative Services Agency
John Bellini, Hillcrest Family Services
Deb Dixon, Dept. of Inspections and Appeals
Sandra Jacques, Tanager Place
Lyle Krewson, Lutheran Services of Iowa
Michelle Licktieg, Wellmark
Kelley Pennington, Magellan
Amber Rand, Children and Families of Iowa

Review of PMIC data
Beth reviewed characteristics of PMICs from the PowerPoint entitled "PMIC Transition Committee: Meeting Two."

- There is a wide range in numbers of beds per facility and numbers of beds in geographical areas.
- The average length of stay (ALOS) is 253 days per child.

- Beth questioned why the certificate of need for Medicaid beds is lower than number of beds actually available. The answer provided by workgroup members was that it was driven by funding for MHI beds. For private PMIC's, most are only staffing beds that are Medicaid funded.
- Question from the group, Will out of state PMICs come under Magellan management? The answer was yes.
- Beth asked the group if the ALOS was changing. The workgroup did not provide comment on any trends.
- Payment methodology was reviewed with no comment.

Review of the matrix document of PMIC responses to survey questions

Beth asked those representing the facilities to discuss the information in the matrix in order to generate discussion of similarities and differences between facilities.

- CFI reviewed information about the facility and identified their specialty as focusing on mental illness, substance abuse, and trauma. The facility is unique in that the focus is on individuals with a primary mental health and secondary substance abuse diagnosis. The severity of those served is considered moderate, not highly aggressive. The facility is always at capacity and always has a waiting list.
- Hillcrest identified that their services are both mental health and substance abuse driven, and are also unique in providing dual diagnosis services. Risk factors of children served include high suicide risk. Occupancy is usually high. The facility is concerned about acuity level measurements when substance abuse is factored in.
- Tanager had no comment beyond what was on the matrix.
- MHI-Independence: most children served are at a higher acuity level and have had unsuccessful placements. The program is described as a comprehensive mental health approach which includes one hour of psychiatry a week. There is no control room or seclusion. Their specialty is working on getting them placed outside the institution. Eligibility is limited to children referred from another state institution such as Eldora, Toledo, Cherokee, or Independence. A question was asked regarding if this was a policy or law? Jennifer Vermeer said the MHI PMIC was set up to not compete with private facilities and is also used as a step down from the acute care unit at MHI, although not all those served by the MHI need it.
- Lutheran Services of Iowa reviewed their facilities. The Bremwood campus serves 12-17 year olds and the Ames campus primarily 5-13 year olds. LSI is unique in that they provide aftercare services for two years post discharge. Both campuses take highly aggressive kids as well as those who run away, and both have seclusion rooms. There is a focus on family involvement.

- Beth questioned if other facilities provide aftercare. CFI said that they do. CFI also said that they don't accept children if families won't be involved. Orchard Place also stated this was their policy.
- Four Oaks serves children ages 5-17. They have contracted psychiatrists and 7 units across two sites. They don't require family involvement, but encourage it. The facility does serve quite a few children who have no family due to being adopted then having rights terminated by the adoptive parents. There is some capacity to serve children with autism and provide sex offender treatment. It appears that younger kids have longer lengths of stay due to familial issues.
- Question from Jennifer Vermeer. Is the difficulty in planning for discharge finding appropriate living situations? Response was that it is also finding day programs or more intensive programs in their communities. They need more than outpatient once a week. There is also a lack of treatment foster care.

Beth posed the question to the group: how do we lower lengths of stay?
Comments:

- There needs to be an intermediary step before children enter a PMIC and step down afterward to shorten lengths of stay. Voluntary placements have brought in more kids who are in active crisis because they haven't had system involvement or services. When kids are ready to discharge they don't have appropriate services to discharge to.
- Parents aren't ready for kids to be discharged.
- Parents don't know how to find the services, people coming in on a voluntary basis.
- Is our ALOS that long? Do we know if it really is too long? What is appropriate?
- Beth responded that it would be different child to child but that other states are looking at shorter lengths of stay as being a desired outcome.
- Permanency issues should be considered also. PMIC's provide community connections and help with transition issues.

Joan Discher asked the group about the differences between children placed voluntarily and those who are adjudicated CINA.
Comments:

- There is a difference-the state of crisis is elevated, it is harder to get information, there is a lack of coordination, it's not a planned or systemic placement.
- Tanager Place stated that CANS scores for children who are voluntary or involuntary are similar. For treatment history, the voluntary population has had more acute care episodes while those adjudicated CINA (Child In Need of Assistance) have more shelter placements. Voluntary children are more crisis-oriented.

- MHI is getting calls direct from parents and having to provide the information on what is available.

Question from Jennifer Vermeer: Are children starting out non-Medicaid eligible, then becoming eligible through institutional placement?
Comments:

- It is more about access to care, not just the coverage. When in crisis, they start calling numbers.
- Parents are being directed to call the PMICs when in crisis.
- Involuntary children have been through the system and will have services afterward. Voluntary children coming from an outpatient or an acute care stay through the PMIC may not have access to services after the PMIC.

What else do they need?
Comments:

- Day treatment with educational services or partial hospitalization.
- Family preservation to deal with crisis and provide short term intervention.
- This is different from BHIS as it would be more intense and more therapeutic.
- The agencies would like to provide a list of what those desired services would be.
- Functional Family Therapy is not funded by Medicaid but can also provide the intensive in-home work some families need.

Question from Joan Discher: If someone calls and says they have a crisis, do you offer other services?

- Members mentioned there were often waiting list for other community based services or other services weren't available to the families.

Question from Jennifer Vermeer: What is the barrier to get the families connected to services before PMIC?
Comments:

- Agencies feel that they try to do that.
- There are few options for high-risk services.
- Families are limited to outpatient or maybe BHIS. Some families don't want to cooperate with services.
- There is less availability of services in rural areas.
- Rural service gaps affect ALOS. For children served by Orchard Place, for those who live in Polk County, the ALOS is shorter, for outside of the county it is longer.
- School issues also make it difficult for kids to transition back home.

- Sometimes one child can be perceived as the problem child of the town, so there is the feeling that if we can just get him sent away somewhere, the problem is solved.
- Comment from Rick Shults -It is a time-limited treatment setting; we have to make sure that people understand that.
- There is a concern about bringing up treatment foster care and day treatment again. Iowa had it before but it was taken away and now it's being brought up again.
- We have seen things come and go: good, working programs went away due to funding, even if they were successful. The question is how much money is available to provide the services under the Magellan contract. There is a concern that beds will need to be decreased to pay for it.
- Beth Waldman stated that the advantage of the Iowa Plan is that money will be available across the system of care. Money can be spent more efficiently.

Comment from Jennifer Vermeer. We can save money on out of state children as we bring them back into Iowa for care, and reinvest those savings on in-state services. It is not a zero sum issue; it is more about rebalancing the system. Other states have gone through this. It is possible to achieve change in how we serve children?

Comments:

- Iowa has tended to identify one service as the "silver bullet" or the answer to the problem, whether it is Family Preservation, Family Centered Services, or Systems of Care. We need to have a service array; there is not just one answer to the problem.
- Child Welfare has become very segregated. It is the opposite of a system of care
- Jennifer Vermeer: DHS is trying to estimate the fiscal impact of recommendations of the redesign workgroup. We have to develop a clear vision of what should be in the system. We have parts of the array that are missing, which is why there were specific recommendations in the workgroup about certain services.
- As we move to a managed care environment and increase the diversity of the array, services have to be available once they don't meet clinical eligibility to support ongoing progress.

Joan Discher: When Magellan took over inpatient psychiatric hospital management, ALOS was reduced in acute care stays. When this happened, Magellan was able to shift money from acute care and moved it to other services. Previously, 50% of dollars were spent on inpatient, whereas it is now about 27%. Are agencies willing to reduce PMIC beds in order to provide upfront services that reduce PMIC usage? Is bed usage driven by matching needs of child to facility or just availability of a bed? Generally, it would be better to serve kids in their local areas.

Comments:

- An agency believes it will have fewer beds under managed care no matter what. If that will mean more services in the array is unclear. We have a tendency to cost-shift kids and move them across systems, which is not beneficial to kids.
- We still need a triage system and we don't have that.
- The population is not big enough to support a lot of specialization in facilities.
- There are small populations of kids who don't progress, move from one place to another, and may not ever make it in the community. They have experienced large numbers of placements and may need a longer length of stay.
- For kids with mental health and intellectual disabilities, the ID system may be a better fit than the mental health system.
- There is a concern that they system may be too rigid and that kids may have to try treatment more than once to be successful.

Question from Joan Discher: How do we figure out how to serve the highest need kids?
Comments:

- Individualized services are important but should be offered in a systemic fashion.
- Sometimes it's a medication issue. They can be highly sensitive to medication changes and be set back by a small change.
- Doctors aren't following medication recommendations following discharge. This impedes their recovery in the community.

Data on Substance Abuse PMICs

Joan reviewed the data on Alegent and Jackson Recovery included in the PowerPoint.

- Most children were authorized for level of care requested.
- The ALOS is 66.4 days. Readmission to either placement is 14% at 30 days.
- 60% went home, other discharge placements were described.

Comments:

- Is it concerning to Magellan that 30% of those discharged went to another kind of group care that is probably DHS and/or Juvenile Justice funded? The challenge will be to not have 30% of the kids go to another residential placement.
- Statistics don't reflect the kids who were in a substance abuse PMIC then went to a mental health PMIC. They may have a really long length of stay or are recidivist but this is not reflected in the Magellan data. There is a concern about the reported ALOS in substance abuse PMICs not being representative of true lengths of stay or services.
- Jennifer Vermeer: It is important to structure performance measures about this.

Beth: Do mental health PMICs know how their discharge data compares to substance abuse PMICs?

Comments:

- Some stated that they don't know. A comment was that since 75% are voluntary, most are returning home.
- How many kids are considered successfully discharged from substance abuse PMIC? How would this be categorized? It's not just where they went but the value of the discharge. Was it to home after successful treatment or to detention due to law violation?
- We need to know who they discharge to, to know how much the system will cost.
- Does the workgroup want the discharge data categorized by successful/not successful and the location of discharge placement?
- Beth will gather data through Kristie Oliver on discharge information from each PMIC.

Review of page 9: What services are being provided in PMICs?

- Comment from Beth: Education component was not really identified in this slide, as well as discharge planning. The workgroup had no comment about this slide.
- Beth reviewed Pg. 11 - findings of the children's redesign workgroup. The preliminary reports for the Children's Disability workgroup and the PMIC Transition workgroup were filed on Oct. 31. The disability workgroup has specific recommendations and the PMIC report includes the plan for the ongoing work of the PMIC workgroup.

Jennifer Vermeer provided a review of the children's disability workgroup recommendations.

- The workgroup discussed other states' service systems, Systems of Care, gaps in the system, and institutional care among other issues. The workgroup focused on lack of coordination of care. Children are not getting what they need but rather what is available. People are calling PMICs directly for lack of other places to seek help.
- Family involvement is important but parents also need help with the transitions.
- There are school issues as children transition back home and educational barriers that affect their ability to be successful.
- There is a lack of step down in the current service array.
- Jennifer also reviewed the overall goals of the redesign process.

Comments

- Is the out of state issue going to be the PMICs task? Jennifer said no, they are part of it, but it is a bigger system issue. The legislative direction was to solve the out of state issue but now we need to do things that address the larger system

issues. PMICs are moving to the Iowa Plan starting July 2012. Specific to out of state children, there will be an RFP to seek contractors to provide a range of services to kids through a health home model. It will probably be funded through community reinvestment. PMICs could start looking at out of state cases and figuring out what they need to be successful in state. DHS also wants to do pilots for an integrated health home for children with SED. There are many things happening simultaneously.

- There is a concern about PMICs being moved to the Iowa Plan prior to other system changes occurring.
- There is a concern about rate issues and the easy exception to policy process that allows DHS to move kids where they want to, whether it's clinically needed or not. This facility hasn't been asked to keep a child at a higher rate to avoid an out of state placement.
- PMICs could help develop an RFP.
- Jennifer Vermeer: Legislation does allow Medicaid to pay a different rate to a PMIC to prevent an out of state placement but providers have not really connected with this. It is hard to do individualized services for one child. The RFP process through Magellan will provide more flexibility in development of the RFP.
- Joan Discher: Providers have been asked to develop a unit for low-functioning, aggressive kids but doesn't believe this has happened. If providers do it on an individualized basis, one kid at a time, Magellan could pay for one on one services if clinically appropriate.
- There should be a small milieu for children with intellectual disabilities. They can't be put in the same group as other kids. The RFP process isn't helpful to the providers in developing services.
- There is a concern that this could repeat the Child Welfare Emergency Services RFP issue. The services are not well defined. It is not required of all providers and the service does not seem to be working.
- It does have to be done one kid at a time.
- The children's disability workgroup just touched the surface of the out of state issue.
- Jennifer Vermeer**:** We don't want to call it an RFP or pilot because that makes it time limited. We get the most flexibility if we include PMIC in the Iowa Plan. We can move on new services faster.
- Beth Waldman suggested an inventory of the kids who are out of state, then next steps based on needs found.
- Can the PMICs look at a couple of kids and really try to proactively plan when it appears that outcomes are not going to be positive?
- Jennifer suggested that they do this before the child is headed out of state.
- How will RAC audits affect use of Magellan to manage PMIC services? Will it affect providers? More flexibility may lead to more audit problems.

- Dennis Janssen stated that the state will probably not recommend RAC audits as IME is already doing a great deal of oversight for managed care and it would be duplicative.

Review of page 15: Workgroup recommendations regarding PMIC services
Beth questioned if there are other things that should happen during the transition to the Iowa Plan such as more performance measurement across the board regarding readmission and ALOS.

Comments

- Why are all readmissions bad? It may support a child's long term recovery.
- Rick Shults stated that we need to compare recidivism against something. Initially it would be to compare all PMICs and look for outliers.
- Regarding rate issues-the CFO's are going to get together to work on the ancillary rate issue in the near future.

Review of page 18: Goals for PMICs in the Transition Plan

- Within legislation there are three specific tasks that are identified as the task of the PMIC workgroup.

  1. Licensing Standards

  - Workgroup was asked for comments or suggested changes.

  Comments

  - DIA staff stated that accreditation is not limited to JCAHO, it could be CARF or COA or other accreditation. The facility has to be licensed as a comprehensive residential group care under DHS.
  - Some regulations are out of date from the 1970's.
  - The PMICs already have a list of regulations that they would like to have addressed. They will recirculate the list of proposed regulations for further review. There is also a concern about audits by multiple organizations including DIA, IME and others.

  2. Prior authorization process-p. 21

  Comments

  - These are federal guidelines. They can't be changed but can there be any process changes?
  - Can the workgroup recommendations regarding flexibility be aligned with the certification process?
  - The group reviewed prior authorization guidelines currently used by Magellan for substance abuse PMICs. How long does it take to get an authorization? Any concerns about this process?
  - Kelly Espeland from IFMC stated that they have a list of PMIC criteria that they review in addition to the federal guidelines. This includes the ability to

benefit from treatment, the need for 24 hour care, risks involved, and history of recent treatment within three months. IME reviews the request a PMIC sends within 24 hours and provides approval. They can only authorize 90 days at a time. Reauthorization is also based on progress, family involvement, new issues, and medication changes among other issues considered.

- Joan Discher states that Magellan does a phone authorization with their SPA-PMIC providers.
- PMIC providers state that they currently have different reviewers; it is more difficult than when they had one assigned reviewer.
- Beth asked why 90 days is the amount of time authorized. Can it be changed?
- Joan stated that Magellan does concurrent reviews more frequently than 90 days.
- How do providers feel about doing phone reviews instead of written reviews?
- It could be easier to do it in writing than the trying to work around scheduling calls.

3. Performance measures-p. 26

What standards are used to measure performance today? ALOS and readmission rates were mentioned.

- Providers said they had already done this work in a previous workgroup. That work was not available to Beth today but she will review the work already done before the next meeting so it is not duplicated.

Comments/Question

Question: Do all the issues listed in the legislation for the PMIC workgroup are really going to be addressed in one more meeting. How can the children's disability workgroup deal with PMIC specific issues?

Response: Most of those issues are being addressed by the larger workgroup, but the PMIC group will be focused specifically on the reimbursement issue. Beth added that this group will cover general as well as ancillary reimbursement issues.

Comment: It is not clear if the children's workgroup covered all of the issues identified. There may need to be a review of the legislation to make sure it is all covered.

Response:	The four things identified for PMICs as different under the Iowa Plan are what were identified as the key issues for this workgroup.
Response:	Beth reviewed the legislation for PMIC workgroup. The tasks are really broader than just PMICs and more appropriate to the larger group.
Comments:	I have concerns about performance measures being developed ahead of available services. Also, are the two workgroups are really coordinated?
Response:	Jennifer Vermeer assured them that their lengths of stay are not going to arbitrarily reduce. It will not be acceptable for Magellan to do this.
Comment:	I have a concern about the focus on ALOS driving the system.
Response:	Jennifer reminded them that the goal is to serve kids in the community and in least restrictive settings.
Comment:	I have a concern about outcome measures being developed by the children's disability group.
Response:	Beth stated that we want to look at what the benchmark of the system is first, and then look at what can be changed and then set goals. This is across the system, and not just the PMICs. The PMIC group will continue to meet throughout the next year as the transition moves forward.
Response:	Jennifer Vermeer stated that we need to look at access, defining the role of the PMIC, who gets it, how they access it, and also making sure kids get out of acute care hospitals when needed.
Comment:	The rate has to be looked at if the system wants beds available on short notice.
Response:	Jennifer stated that if we can get the lower level kids out of the PMIC to the community or keep them there in the first place, then we can serve the higher needs kids in the PMIC more effectively.

Comment:	If the PMIC group could have a plan about how the two workgroups are connected that would be helpful. Right now it feels like the cart is before the horse.
Comment:	There is a concern that providers will bear the financial cost of the system changes.
Comment:	Providers have not done well at reporting outcomes or defining successful outcomes. Short lengths of stay don't encourage relationships and social connections.
Question:	Do providers track outcomes after discharge?
Response:	Generally not.
Question:	How have other states moved PMIC to Managed Care successfully?
Response:	Pennsylvania is an example.
Response:	Rick Shults stated that we can look at the data from other states.
Response:	Beth Waldman stated that Iowa's service is not very comparable to other states, it is unique.
Comment:	There would be value in looking at the legislation and dialoguing about what needs to happen that wasn't covered in the first report and make recommendations for further work.

Adjourn

The next meeting will be December 7 from 12:30-3:30pm. The topic will be changes to licensure and standards, and rate setting. The ancillary costs subgroup will start meeting soon. Those meetings will be conducted by phone.

For more information:

Handouts and meeting information for each workgroup will be made available at: http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.